PRINTED: 06/09/2008 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |      |  | (X3) DATE SURVEY COMPLETED                    |                            |
|---|---|---|---|------|--|---|----------------------------|
|   |   | 09G141  | B. Wit                                  | NG   |  | 05/30   | 0/2008                     |
| NAME OF P   | ROVIDER OR SUPPLIER   |   |   | 14   | EET ADDRESS, CITY, STATE, ZIP CODE<br>133 NORTHGATE ROAD, NW<br>(ASHINGTON, DC 20012   |   |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG                       |      | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY)  | IOULD BE                                      | (X5)<br>COMPLETION<br>DATE |
|   | 28, 2008, through fundamental surve of three clients was population of six fe and other disabilities based on observatione day program, records, including 483.410(c)(4) CLIE Any individual who record must make  This STANDARD Based on interview failed to ensure the record was signed clients (Client #1)  The findings included the findings included the included in the same form. In the same form in the same form in the same form. Respecific sections we the assessment (candidate it after its the form failed to pannual assessment dated by the nurse assessment. | rvey was conducted from May May 30, 2008, using the y process. A random sample is selected from a residential emales with mental retardation in the group home and at interviews, and a review of unusual incident reports. ENT RECORDS  makes an entry in a client's it legibly, date it, and sign it.  is not met as evidenced by:  y and record review, the facility at each entry into a client's and dated, for one of three included in the sample. | W                                       | 1114 | GOVERNMENT OF THE DISTANCE OF THE DISTANCE OF THE ALTH REGULATION 825 NORTH CAPITOLS WASHINGTON  W 114  1. In the future the R Supervisor will ensuthat all reports are reviewed for complete See attached Annual Health Service Summa signed and dated.  2. In the future all incidents will be presented to the Hurlinghts committee for review. All incidents occurring at the day program will also be presented and reviewed. | N are etion. man -                            | TION                       |
| LABORATOR   | _   | DER/SUPPLIER REPRESENTATIVE'S SIG   | <br>NATURE                              |      | TITLE  | <u>, , , , , , , , , , , , , , , , , , , </u> | (X6) DATE                  |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 09G141

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER:   |        | LDING   | PLE CONSTRUCTION  3   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|--------|---|---|-------------------------------|----------------------------|
|   |  | 09G141   | B. WII | NG  |   | 05/3                          | 0/2008                     |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |        | 14  | EET ADDRESS, CITY, STATE, ZIP CODE<br>433 NORTHGATE ROAD, NW<br>/ASHINGTON, DC 20012  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   |        | ID PROVIDER'S PLAN OF CO<br>PREFIX (EACH CORRECTIVE ACTION<br>TAG CROSS-REFERENCED TO THE<br>DEFICIENCY |   | DULD BE                       | (X5)<br>COMPLETION<br>DATE |
| W 114 W 148   | involving Client #1 483.420(c)(6) CON CLIENTS, PAREN The facility must no parents or guardial changes in the clie limited to, serious or unauthorized ab  This STANDARD Based on interview failed to ensure gu incidents, for one clincluded in the san The finding include Interview with the finding include Interview with the finding incidence corresponding involute 2008, beginning at following:  On November 20, reported noticing Con The client was obsother clients on as upon visual exami near her left thigh examination of the human bite mark with Interview with the 2008 revealed Clie Continued review | was dated. (See W156) MMUNICATION WITH TS &  potify promptly the client's an of any significant incidents, or ant's condition including, but not fillness, accident, death, abuse, asence.  is not met as evidenced by: and record review, the facility ardians were notified of serious of the three clients (Client #1) anple.  es: facility's Qualified Mental asional (QMRP) and review of ants reports, including available estigative reports, on May 28, and 10:30 AM revealed the  2007, day program staff Client #1 crying "really hard." served to be seated next two asofa. Staff documented that anation, Client #1's left pant leg, was wet. After closer area, staff revealed that a |        | 114   | Metro Homes, Inc. foll an Incident Manageme Policy and Procedure. QMRP has been in serviced on Incident Management and Reporting.  See attached In servic record. | ent<br>The                    | 6/16/08                    |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTI   | PLE CONSTRUCTION    | (X3) DATE SURVEY  |                                |                            |
|---|--|--|---------------------|---|--------------------------------|----------------------------|
| STATEMENT<br>AND PLAN C                               | OF DEFICIENCIES OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDIN          |   | COMPL                          |                            |
|   |  | .09G141  | B. WING _           |   | 05/3                           | 30/2008                    |
| NAME OF P   | ROVIDER OR SUPPLIER  |  | 1.                  | REET ADDRESS, CITY, STATE, ZIP (<br>433 NORTHGATE ROAD, NW<br>VASHINGTON, DC 20012      | CODE                           |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (FACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIVE<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| W 149   | client's legal guard aforementioned ind 483.420(d)(1) STA CLIENTS  The facility must depolicies and proceed mistreatment, neglements and proceed mistreatment, neglements and proceed in the stream of the client's the three clients (Cosample).  The finding included the facility failed to establish a ensured the client's the three clients (Cosample).  The finding included the facility failed to establish a ensured the clients of the facility's incide available corresponding to the facility's incide available corresponding to the following:  On November 20, reported noticing of the client was obsother clients on a supon visual examinear her left thigh examination of the human bite mark was also the client was obsother clients on a supon visual examinear her left thigh examination of the human bite mark was also the client was obsother clients on a supon visual examinear her left thigh examination of the human bite mark was also the clients of the human bite mark was also the clients of the human bite mark was also the clients of the human bite mark was also the clients of the human bite mark was also the clients of th | ian had been notified of the cident.  FF TREATMENT OF  evelop and implement written dures that prohibit lect or abuse of the client.  is not met as evidenced by:  y and record review, the facility and/or implement policies that is health and safety, for two of client #1 and #2) included in the less:  o ensure the implementation of gement" policy as outlined.  the facility's Qualified Mental issional (QMRP) and review of ints reports, including the less and investigative reports, on ginning at 10:30 AM revealed  2007, day program staff client #1 crying "really hard." It is served to be seated next two sofa. Staff documented that ination, Client #1's left pant leg, was wet. After closer is area, staff revealed that a was observed. | W 149               |   | ursing<br>serviced<br>Policy   | 6/16/08                    |
| 1   | Continued review   | of the facility's incident reports   |                     |   |                                |                            |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A. BUI  |      | IPLE CONSTRUCTION  IG   | (X3) DATE SURVEY<br>COMPLETED |        |
|--------------------------|---|---|---|------|---|-------------------------------|--------|
|                          |   | 09G141  | B. WIN  | IG _ |   | 05/3                          | 0/2008 |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |   | 1    | REET ADDRESS, CITY, STATE, ZIP CODE<br>433 NORTHGATE ROAD, NW<br>NASHINGTON, DC 20012 |                               |        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | EDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE |      | (X5)<br>COMPLETION<br>DATE  |                               |        |
| W 149                    | failed to provide evaforementioned incimmediately to the officials in accordant Additionally, the fact that the incident was allegations of abuse allegations of abuse allegations of abuse and via written doc survey, the facility of Management Policips. Client #2 was of 10:35 AM arriving the was observed cryinally shoes or socks the day program's in not wearing any shows hurting. The document of the examine the client was a calloused area and touch. After the cliprogram staff containing for her to be could be further evaluated in the facility. The hoshe did not know we was a did not know | idence that the bident was reported administrator or to other ince with State law. Sility failed to provide evidence as thoroughly investigated.  MRP and review of the anagement Policy on May 29, incident involving Client #1 on 7 would be classified as an . According to the policy, are require notifications to be timent of Health both verbally umentation. At the time of the failed to ensure its Incident by was implemented.  In bserved on May 29, 2008, at to her day program. The client grand she was not wearing and she was not wearing at the facility staff reported to be sensitive to dent's examination, a day acted the facility in order to be picked up so that her toe | W 1   |      |   |                               |        |

| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIF         | PLE CONSTRUCTION  |         | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|---------------------|---|---------|-------------------------------|--|
|                          |   | 09G141   | B. WING             |   | 05/3    | 0/2008                        |  |
| NAME OF P                | ROVIDER OR SUPPLIER   |  | 14                  | EET ADDRESS, CITY, STATE, ZIP CODE<br>433 NORTHGATE ROAD, NW<br>VASHINGTON, DC 20012                |         | - 1                           |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| W 149                    | tight. According to removing the client the client stopped of the house manager medication nurse wand was informed of The house manager nurse indicated that toe and contact the However, there was that Client #2 was of the However, there was that Client #2 was of the "Incident reports on evicece that the incidents were mar steps:  1. The prompt reprobservations of incident reports.  2. Prompt staff into incident reports.  3. Prompt medical community support.  4. Timely and according and representations and representations.  5. Investigation and 6. Personnel actionals. | the house manager, after 's Ted Hose she noticed that crying. Further interview with a revealed the facility's vas in the facility at that time, of the aforementioned concernser revealed that the medication it she would check the client's facility's nurse coordinator. Is no documented evidence examined by the nurse.  That review of the facility's May 28, 2008, failed to provide cident was documented.  The management' policy on 100 AM revealed that the maged by the following listed corting of all allegations or idents involving individuals.  The erventions and generation of a treatment or contact with the personnel.  The treatment or diffication of a treatment or diffication or difficatio | W 149               |   |         |                               |  |
| 1                        | 7. Review and cor   | rective action to prevent the  |                     |   |         |                               |  |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MU<br>A. BUIL  | ILTIPLE CONSTRUCTION DING   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|--|---------------------|---|-------------------------------|----------------------------|
|                          |  | 09G141   | B. WING             | G   | 05/3                          | 30/2008                    |
| NAME OF F                | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP COI<br>1433 NORTHGATE ROAD, NW<br>WASHINGTON, DC 20012 | ÞE                            |                            |
| (X4) ID<br>PRÉFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)    | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| W 149                    | and investigating in  9. Data collection a means to develop p service plans for inc serious incidents fro  At the time of the si implement their Inc recommended.  483.420(d)(2) STAI CLIENTS  The facility must en mistreatment, negle injuries of unknown immediately to the officials in accordar established procede  This STANDARD i Based on interview failed to ensure tha immediately reporte other officials in acc one of the three clie sample.  The finding includes Interview with the fa Retardation Profess the facility's inciden corresponding inve | preventing, detecting, reporting cidents; and and trending analysis as a preventative strategies and dividuals to prevent more om occurring.  The arms of the facility failed to ident Management policy as a source, are reported administrator or to other nace with State law through ures.  The arms of abuse were and record review, the facility the all allegations of abuse were and to the administrator or to cordance with State law, for ents (Client #1) included the | W 1                 |   | <b>.</b>                      |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | A. BU             |      | NG  | COMPL    |                            |
|--------------------------|--|--|-------------------|------|---|----------|----------------------------|
|                          |  | 09G141   | B. WII            | NG _ |   | 05/3     | 30/2008                    |
| NAME OF P                | ROVIDER OR SUPPLIER  |  | •                 | •    | REET ADDRESS, CITY, STATE, ZIP CODE<br>1433 NORTHGATE ROAD, NW<br>WASHINGTON, DC 20012              |          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |      | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| W 153                    | following:  On November 20, reported noticing of The client was obsother clients on a supon visual examinear her left thigh examination of the human bite mark view of the facility evidence that the immediately to the officials in accordadas.420(d)(3) STACLIENTS  The facility must his violations are thoroughly investigation of the facility investigation of the facility's incidents (Client #1)  The finding included Interview with the Retardation Profession of the facility's incidents available corresponding 28, 2008, beginned to the facility of the following:  On November 20, reported noticing of the facility of the facility of the facility of the facility of the following: | 2007, day program staff Client #1 crying "really hard." served to be seated next two sofa. Staff documented that nation, Client #1's left pant leg, was wet. After closer area, staff revealed that a was observed. Continued ty's incidents failed to provide incident was reported administrator or to other ance with State law. AFF TREATMENT OF  ave evidence that all alleged oughly investigated.  is not met as evidenced by: w and record review, the facility at allegations of abuse were gated, for one of the three included in the sample. | w                 | 153  |   | b        |                            |
|                          | , ,,o onone was ob.  | sssa to so ocator none the   |                   |      |   |          |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) M<br>A. BUI  |     | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|--|-------------------|-----|--|-------------------------------|----------------------------|
|                          |  | 09G141   | B. WIN            | IG  |  | 05/30/2008                    |                            |
| NAME OF P                | ROVIDER OR SUPPLIER  |  | •                 | 14  | EET ADDRESS, CITY, STATE, ZIP CODE<br>I33 NORTHGATE ROAD, NW<br>(ASHINGTON, DC 20012   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF THE APPR | ULD BE                        | (X5)<br>COMPLETION<br>DATE |
| W 154                    | upon visual examination near her left thigh vexamination of the human bite mark we Continued review of corresponding invertieve aled that Clien program nurse for program's inter-age November 20, 200 "imprint of teeth prono obvious breaks with antibacterial see ER for further evaluation of the compolice and EMS are was not necessary emergency room diskin was still intact. Additional review of and interview was May 28, 2008 to denurse requested elemants. | ofa. Staff documented that pation, Client #1's left pant leg, was wet. After closer area, staff revealed that a was observed.  of the incident report and estigative summary (not dated) at #1 was seen by the day evaluation. Review of the day evaluation. Review of the day ency communication (dated 7) revealed that there was an ominent in skin but there were in the skin. Area cleansed oap and water. To be taken to uation and treatment." Further nunication revealed that the rived and determined that it to transport the client to the lue to the fact that Client #1's of the incident report package conducted with the QMRP on etermine why the day program mergency medical services. At | W                 | 154 |  |                               |                            |
| W 156                    | be determined. Further evidence that invest name of the perperinvestigation report conducted with all that evaluated Clie 483.420(d)(4) STA CLIENTS  | FF TREATMENT OF  | w                 | 156 |  |                               |                            |
|                          | to the administrato  | nvestigations must be reported<br>or or designated representative<br>in accordance with State law  |                   |     |  |                               |                            |

|                          | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | A, BUI            | LDING |  | COMPLETED                         |                            |
|--------------------------|--|---|-------------------|-------|--|-----------------------------------|----------------------------|
|                          |  | 09G141  | B. VVII           | NG    |  | 05/30                             | 0/2008                     |
| NAME OF P                | ROVIDER OR SUPPLIER  |   |                   | 14    | EET ADDRESS, CITY, STATE, ZIP CODE<br>433 NORTHGATE ROAD, NW<br>VASHINGTON, DC 20012   |                                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |       | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)   | OULD BE                           | (X5)<br>COMPLETION<br>DATE |
| W 156                    | within five working This STANDARD Based on interview   | days of the incident.  is not met as evidenced by:  and record review, the facility   | W                 | 156   | W 156  |                                   |                            |
|                          | reviewed by the active working days, (Clients #1) include  | •   |                   |       | Refer to W 148   |                                   |                            |
| W 159                    | Qualified Mental R (QMRP) and revier reports, including to investigative report at 10:30 AM reveal #1 dated November report, Client #1 white mark on her less corresponding investigation was report was signed ated. Additionally investigation was readministrator or de 483.430(a) QUALI RETARDATION PRETARDATION PRETARDA | etardation Professional w of the facility's incidents the available corresponding ts, on May 28, 2008, beginning led an incident involving Client er 20, 2007. According to the as observed to have a human eft thigh. Review of the estigative summary revealed ned by the QMRP but was not y, there was no evidence the reviewed by the facility's esignee. FIED MENTAL | W                 | 159   | W 159  1. The QMRP has purchased new an appropriate fittin clothing for this c  2. Staff were in serv on the toileting program and the QMRP will monitor this program at lemonthly to ensure completion. | g<br>lient.<br>iced<br>or<br>east |                            |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G141  | A. BUIL<br>B. WIN  | DING |   | COMPLI                                    | ETED                       |
|--------------------------|---|---|--------------------|------|---|---|----------------------------|
| NAME OF B                | ROVIDER OR SUPPLIER   | 09G(41  | 1                  | CTDI | EET ADDRESS, CITY, STATE, ZIP CODE  | 05/3                                      | 30/2008                    |
| METRO 1                  |   |   |                    | 14   | 33 NORTHGATE ROAD, NW ASHINGTON, DC 20012   |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | 1    | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)  | QULD BE                                   | (X5)<br>COMPLETION<br>DATE |
| W 159                    | Professional (QMF) The findings included.  1. The QMRP failly employee was protraining that enable or her duties effection for her duties effection for the Interdisciplinar client's Individual received continuous of needed interverw249)  3. The QMRP fail Individual Program and revised once completed an object.  4. The QMRP fail were effectively trace of the completed an object.  4. The QMRP fail were effectively trace in the completed an object.  The facility must printial and continuity employee to perfect efficiently, and continuity employee to perfect failed to ensure the with initial and continuity in the facility and continuity in the facility and continuity employee to perfect failed to ensure the with initial and continuity in the facility and continuity in | de:  ed to ensure that each vided with initial and continuing ed the employee to perform his tively, efficiently, and e W189)  ed to ensure that as soon as y Team (IDT) formulated each Program Plan (IPP), clients us active treatment, consisting intions and services. (See  ed to provide evidence that in Plans (IPP)s were reviewed the client had successfully ective, (See W255)  ed to to ensure employees ained to provide foot care for (192)  AFF TRAINING PROGRAM  provide each employee with ing training that enables the form his or her duties effectively, | W 1                |      | 3. The ambulating program has been discontinued. In the future the QMRP wensure that program are reviewed at least monthly and appropriate revisition are made in a time manner.  4. The staff were retrained in foot care the client.  In the future the QMRP at Nursing staff will ensure all Programs and In service are completed and on go to ensure staff are able to perform their duties effectively and efficiently. | e vill ams ast ons ely e for that ces ing |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |   | (X2) M<br>A. BUI            |   | TIPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |         |
|---|--|---|-----------------------------|---|--|-------------------------------|---------|
|   |  | 09G141  | B. WI                       | NG_   |  | 05/30                         | )/2008  |
| NAME OF P   | ROVIDER OR SUPPLIER  |   |                             |   | REET ADDRESS, CITY, STATE, ZIP CODE<br>1433 NORTHGATE ROAD, NW<br>WASHINGTON, DC 20012   | -                             |         |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (E)   |   | (EACH CORRECTIVE ACTION SHO | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  |                               |         |
| W 189   | Continued From pa  | age 10  | W                           | 189   |  |                               |         |
| W 192   | were effectively tradressing appropriated dressing appropriated appropriated as 28, 2008 at 3: wearing yellow crosto be made of a costo the client allowing Undergarment (AF were queried as to observation of her assisted the client On May 30, 2008 as again observed to closely. The impresobserved in the frosthe back. Interview the client had receive the client had received the staff member, room and was assent the time of the sensure staff were accordingly with the client #1 with dressing maintain levels of 483.430(e)(2) STAF For employees with the staff memployees with the staff mempl | provide evidence that staff ined on assisting clients with tely.  ent #1 entering the facility on 37 PM revealed the client was plants. The pants appeared tton-like material and fit closely in the fit of Client #1's pants and APU, staff immediately to change her clothing.  ent 12:20 PM, Client #1 was be wearing pants that fit ession of the client's APU was not of the client's pants and in with the staff revealed that ently gained weight and many of essely. After the discussion with Client #1 was escorted to her ested with changing her clothes.  Estrucy, the facility failed to effectively trained to assist sing appropriately in order to privacy.  EF TRAINING PROGRAM  o work with clients, training is and competencies directed | W                           | 192   | Client has new clothing purchased.  All staff were in services Client Rights and Privace |                               | 6/16/08 |
|   | This STANDARD  | is not met as evidenced by:   |                             |   |  |                               |         |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT (X2) MULTIPLE CONSTRUCT (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/ |   |   | (X3) DATE SURVEY COMPLETED |         |   |      |        |
|--|---|---|----------------------------|---------|---|------|--------|
|  |   | 09G141  | B. WI                      | NG      | <u> </u>  | 05/3 | 0/2008 |
| NAME OF P  | ROVIDER OR SUPPLIER   |   |                            | 1       | REET ADDRESS, CITY, STATE, ZIP CODE<br>433 NORTHGATE ROAD, NW<br>VASHINGTON, DC 20012 |      |        |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   |                            | OULD BE | (X5)<br>COMPLETION<br>DATE  |      |        |
| W 192  | Based on observat<br>review the facility for<br>were effectively tra  | cion, interview and record<br>ailed to ensure employees<br>ined to provide foot care, for<br>ents (Client #2) included in the   | W                          | 192     |   |      |        |
|  | revealed Client #2 wheelchair. The c between each of h facility's Registered aforementioned da inservice training of Continued intervied inservice was sche staff on proper food to the RN, staff we on Client #2's feet.   | ay 30, 2008 at 4:00 PM sitting barefoot in her lient was observed with gauze er toes. Interview with the d Nurse (RN) on the ate revealed that she held an on May 29, 2008 at 3:00 PM. w with the RN revealed that the eduled to train the direct care to care for Client #2. According are trained to place cotton socks Additionally, they were the client's feet to air out in realing.  | ,                          |         | W 192<br>Refer to W 159 – 4   |      |        |
| W 249  | nursing progress r<br>nursing progress r<br>staff had been inso<br>3:00 PM. The not<br>agenda included p<br>Additionally, the in<br>between the client<br>balls and/or gauze<br>Although Client #2<br>between her toes,<br>wore the cotton so<br>facility's RN. At th<br>failed to ensure sta<br>to address Client #2 | 2's medical record revealed a note dated May 29, 2008. The note verified that the direct care erviced on May 29, 2008 at a also verified that the inservice roper foot care for Client #2. service addressed airing in a stoes and the use of cotton pads between her toes. was observed with gauze there was no evidence that she acks as recommended by the etime of the survey, the facility aff were trained effectively #2's health needs. | W                          | 249     |   |      |        |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER:  |           | LDING   | LE CONSTRUCTION   | COMPLETED |                            |
|--|--|---|-----------|---|---|-----------|----------------------------|
|  |  | 09G141  | B, WIN    | 1G  |   | 05/3      | 30/2008                    |
| NAME OF P  | ROVIDER OR SUPPLIER  |   |           | STREET ADDRESS, CITY, STATE, ZIP COE<br>1433 NORTHGATE ROAD, NW<br>WASHINGTON, DC 20012 |   |           |                            |
| (X4) ID<br>PREFIX<br>TAG                         |  |   | FULL PREF |   | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE  | (X5)<br>COMPLETION<br>DATE |
| W 249  | formulated a client<br>each client must re<br>treatment program<br>interventions and s<br>and frequency to s   | erdisciplinary team has 's individual program plan, eceive a continuous active consisting of needed services in sufficient number upport the achievement of the d in the individual program   | W 2       | 249   |   |           |                            |
|  | Based on interview failed to ensure ear active treatment sectionts (Client #1) in the finding included Review of Client #10.50 AM revealed Support Plan (ISP) Interview with the Composition of Compositi | 1's records on May 29, 2008 at I the client had an Individual dated December 18, 2007. Qualified Mental Retardation RP) on May 29, 2008 and lient #1's record revealed that SP meeting, the am recommended program g the following:  pts, Client #1 will use the toilet of the trials for three |           |   | W 249<br>Refer to W159 2  |           |                            |
| W 255  | the client's records<br>the aforementioned<br>implemented.   | with the QMRP and review of stailed to provide evidence that d program objective had been cOGRAM MONITORING &   | W 2       | 255   |   |           |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                   |     | (X3) DATE SURVEY<br>COMPLETED   |         |                            |
|--|---|---|-------------------|-----|---|---------|----------------------------|
|  |   | 09G141  | B. WI             | NG_ | ·   | 05/3    | 0/2008                     |
| NAME OF P  | ROVIDER OR SUPPLIER   |   |                   | •   | REET ADDRESS, CITY, STATE, ZIP CODE<br>1433 NORTHGATE ROAD, NW<br>WASHINGTON, DC 20012                |         |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| W 255  | least by the qualifie professional and rebut not limited to sit successfully complidentified in the indidentified in the individual Professional (QMR that Individual Progreviewed and revise successfully complethe three clients (C sample.  The finding include Review of Client #1 10:50 AM, revealed Plan (ISP) meeting 2007. Interview with client's correspondithe team recomme including the follow - Given verbal cues and down stairs, 5 for 12 consecutive - Given physical as ambulate for 10 conweek for 12 consecutive - Given physical as ambulate for 10 conweek for 12 consecutive | ram plan must be reviewed at d mental retardation vised as necessary, including, tuations in which the client has eted an objective or objectives vidual program plan.  s not met as evidenced by: and record review, the Mental Retardation P) failed to provide evidence ram Plans (IPP)s were ed once the client had eted an objective, for one of lient #1) included in the s:  's record on May 29, 2008 at if the client's Individual Support was held on December 18, the QMRP and review of the ing IPP at 4:12 PM revealed inded program objectives ing for the current ISP year:  s, Client #1 will ambulate up repetitions, 3 days per week months.  sistance, Client #1 will insecutive minutes, 3 days per | W                 |     | W 255<br>Refer to W 159 – 3   |         |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MU<br>A. BUIL   | JLTIPLE CONSTRUCTION  DING |   | (X3) DATE SURVEY<br>COMPLETED                       |                            |
|---|--|--|----------------------------|---|---|----------------------------|
|   |  | 09G141   | B. WIN                     | G   | 05/3  | 30/2008                    |
| METRO   | PROVIDER OR SUPPLIER   |  |                            | STREET ADDRESS, CITY, STATE, ZIP<br>1433 NORTHGATE ROAD, NW<br>WASHINGTON, DC 20012 | , CODE  |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF  (EACH CORRECTIVE ACT  CROSS-REFERENCED TO 1  DEFICIENCE         | TION SHOULD BE<br>THE APPROPRIATE                   | (X5)<br>COMPLETION<br>DATE |
| W 322   | review on May 30, 2 achieved the criteria. 2007. According to review, the objective Client #1 in 2006. QMRP failed to ensobjectives were reviciteria. 483.460(a)(3) PHY  The facility must prigeneral medical can be according to the facility from the facility from the facility from the findings included the findings included the client #2 was obsequently from the findings included the client #2 was obsequently from the finding the client to the nurnoted that Client #2 Continued observative wearing any shoes day program staff, the client was not we because her foot will nurse proceeded to the client was not we have proceeded to the client was | 2008 revealed Client #1 a for the aforementioned two prior to the ISP in December of further interview and record es were first introduced to At the time of the survey, the sure Client #1's program ised after the client achieved SICIAN SERVICES ovide or obtain preventive and re.  s not met as evidenced by: on, interview and record ailed to ensure timely general are services, for one of the a #2) included in the sample. | W 2                        |   | staff will<br>its' receive<br>atment.<br>staff were | 6/16/08                    |

|                          | ATEMENT OF DEFICIENCIES DEPARTMENT OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING  |   |                   |     | (X3) DATE SURVEY<br>COMPLETED   |                                |                            |
|--------------------------|---|---|-------------------|-----|---|--------------------------------|----------------------------|
|                          |   | 09G141  | B. WIN            | IG  |   | 05/3                           | 30/2008                    |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                   | 143 | ET ADDRESS, CITY, STATE, ZIP (<br>33 NORTHGATE ROAD, NW<br>ASHINGTON, DC 20012        | CODE                           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| W 322                    | examination reveal observed with a da appeared to be ser further observed C on her right leg tha the top of her foot. examination, a day facility in order to a so that her toe cou  At 10:45 AM, the fa Client #2. In route observed the facility program. Client #2 | led that Client #2 's toe was rk calloused area and it nsitive to touch. The nurse lient #2 with a long red mark it extended below her knee to After the client's r program staff contacted the arrange for her to be picked up ld be further evaluated.  acility's staff arrived to pick-up to the facility, the surveyor ry's van parked at another day was transported on that van to the facility for medical | W                 | 322 |   |                                |                            |
|                          |   |   |                   |     |   |                                |                            |

|                          | T OF DEFICIENCIES<br>DE CORRECTION   | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU  |  | A. BUILDING                        | PLE CONSTRUCTION   | (X3) DATE S<br>COMPL   |                          |  |  |  |
|--------------------------|--|--|--|------------------------------------|--|------------------------|--------------------------|--|--|--|
|                          |  | 09G141   |  | B. WING                            |  | 05/3                   | 30/2008                  |  |  |  |
| NAME OF P                | ROVIDER OR SUPPLIER  |  | STREET AD  | ADDRESS, CITY, STATE, ZIP CODE     |  |                        |                          |  |  |  |
| METRO I                  | HOMES  |  |  | RTHGATE ROAD, NW<br>GTON, DC 20012 |  |                        |                          |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENCY   | TEMENT OF DEFICIENCIE<br>MUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA   | FULL   | ID<br>PREFIX<br>TAG                | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIOI<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)   | N SHOULD BE            | (X5)<br>COMPLETE<br>DATE |  |  |  |
| R 000                    | INITIAL COMMEN   | TS   |  | R 000                              |  |                        |                          |  |  |  |
|                          | A re-licensure surve 28, 2008, through is sample of three respective details and oth findings were based home and at one direview of records, is reports.  4701.5 BACKGRO  The criminal backgoriminal history of the contract worker for in all jurisdictions were based on interview deceds disclosed the prospective employer or contract worker for in all jurisdictions were check.  This Statute is not based on interview deceds disclosed the prospective employer or contract worker for in all jurisdictions were checks disclosed the checks disclosed the prospective employer or contract worker had worked (7) years prior to the the finding included interview with the Control of the Con | ey was conducted from May 30, 2008. A rand sidents was selected on of six females with er disabilities. The sident on observations in any program, interview notuding unusual incompleted on the prospective employed the previous seven within which the prospective employed from the properties of the pr | dom from a h mental survey the group ws, and a sident  IIREMENT sclose the oyee or (7) years, bective ed or to the ground any er for the ions within tract e seven  Services records on M revealed ence that e and e |                                    | R 125  The agency has a polyprocedure on criminal background checks from the employees — prior to and employment.  Attached are the criminal background checks | al<br>or new<br>hiring | 6/16/08                  |  |  |  |
| •                        | Ilation Administration  WWW  YORECTOR'S OR PROVI   | Slow fr<br>der/supplier represe  | BSN MK<br>NTATIVE'S SIG  |                                    | VI, Ofliations   | 6                      | (X6) DATE                |  |  |  |

STATE FORM

|                          | T OF DEFICIENCIES<br>OF CORRECTION               | (X1) PROVIDER/SUPPLIE<br>IDENTIFICATION NUI | R/SUPPLIER/CLIA<br>ATION NUMBER: |  | PLE CONSTRUCTION  G  | (X3) DATE SURVEY<br>COMPLETED |                          |  |  |  |
|--------------------------|--|---|----------------------------------|--|--|-------------------------------|--------------------------|--|--|--|
|                          |  | 09G141                                      |                                  |  |  | 05/3                          | 0/2008                   |  |  |  |
| NAME OF P                | ROVIDER OR SUPPLIER                              |   |                                  | EET ADDRESS, CITY, STATE, ZIP CODE         |  |                               |                          |  |  |  |
| METRO                    | HOMES  |   | 1433 NOR<br>WASHING              | 3 NORTHGATE ROAD, NW<br>SHINGTON, DC 20012 |  |                               |                          |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL |   |                                  | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE                      | (X5)<br>COMPLETE<br>DATE |  |  |  |
| R 125                    | Continued From pa                                | ge 1  |                                  | R 125                                      |  |                               |                          |  |  |  |
|                          | worked for eight sta                             |   |                                  |  |  |                               |                          |  |  |  |
|                          |  |   |                                  |  |  |                               |                          |  |  |  |
|                          |  |   |                                  |  |  |                               |                          |  |  |  |
|                          |  |   |                                  |  |  |                               |                          |  |  |  |
|                          |  |   |                                  |  |  |                               |                          |  |  |  |
|                          |  |   |                                  |  |  |                               | ·                        |  |  |  |
|                          |  |   |                                  |  |  |                               |                          |  |  |  |
|                          |  |   |                                  |  |  |                               |                          |  |  |  |
|                          |  |   |                                  |  |  |                               |                          |  |  |  |
|                          |  |   |                                  |  |  |                               |                          |  |  |  |

Health Regulation Administration STATE FORM

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/\$UPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 05/30/2008 09G141 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1433 NORTHGATE ROAD, NW **METRO HOMES** WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 1 000 1000 INITIAL COMMENTS A re-licensure survey was conducted from May 28, 2008, through May 30, 2008. A random sample of three residents was selected from a residential population of six females with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews, and a review of records, including unusual incident reports. 1082 1 082 3503.10 BEDROOMS AND BATHROOMS 6/16/08 Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup I 082 dispenser, soap for hand washing, a mirror and adequate lighting. The toilet paper holder was replaced and staff were in serviced. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure each bathroom was equipped In the future the OMRP and with a paper towel holder. House Manager will ensure the environment is The finding includes: appropriately maintained. Observations of the GHMRP's environment and interview with the House Manager during the environmental walkthrough on May 29, 2008 at approximately 2:40 PM revealed there was no functional toilet paper holder in the bathroom located in the far bedroom. It should be noted that toilet paper was observed to be housed on the back of the toilet. . 1090 1090 3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATION

N-Oferations

(X6) DATE

If continuation sheet 1 of 10

PRINTED: 06/09/2008 FORM APPROVED (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 05/30/2008 09G141 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1433 NORTHGATE ROAD, NW **METRO HOMES** WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAĠ DEFICIENCY) 1090 Continued From page 1 accumulations of dirt, rubbish, and objectionable I 090 odors. 6/16/08 The bathroom faucet was This Statute is not met as evidenced by: fixed. Based on observation and interview, the GHMRP failed to ensure the interior of the facility was In the future the QMRP and maintained in a safe, clean, orderly, attractive and House Manager will ensure sanitary manner. the environment is The findings include: appropriately maintained. Observation and interview with the House Manager during the environmental walkthrough on May 29, 2008 at approximately 2:40 PM revealed the following: Bathroom The sink in the bathroom located in the bedroom at the far end of the hall, leaked water from the faucet and the water temperature handles. I 203 1203 1203 3509.3 PERSONNEL POLICIES All employees receive an Each supervisor shall discuss the contents of job 6/16/08 annual appraisal and sign a descriptions with each employee at the beginning employment and at least annually thereafter. job description - initial and

Health Regulation Administration

The finding includes:

This Statute is not met as evidenced by:

supervisor discussed the contents of job

Based on interview and record review, the

GHMRP failed to provide evidence that the

of their employment and annually thereafter.

Interview with the Qualified Mental Retardation Professional and review of the GHMRP's

descriptions with each employee at the beginning

annually according to the

the QMRP and the HR

employee records are

Agency Policy. In the future

Department will ensure all

updated according to policy.

See attached job descriptions.

| AND PLAN OF CORRECTION IDENTIFICATION N |   | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU  |   | (X2) MULTI<br>A. BUILDIN<br>B. WING | PLE CONSTRUCTION  G  | (X3) DATE SURVEY COMPLETED 05/30/2008 |                          |
|---|---|--|---|-------------------------------------|--|---------------------------------------|--------------------------|
| NAME OF P                               | ROVIDER OR SUPPLIER   |  | STREET ADI  | DRESS, CITY, S                      | STATE, ZIP CODE  |                                       | •                        |
| METRO I                                 | HOMES   |  | 1433 NOR<br>WASHING   | THGATE ROTON, DC 2                  | OAD, NW<br>0012  |                                       |                          |
| (X4) ID<br>PREFIX<br>TAG                | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY<br>LSC IDENTIFYING INFORMA  | FULL  | ID<br>PREFIX<br>TAG                 | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)    | SHOULD BE                             | (X5)<br>COMPLETE<br>DATE |
| I 203                                   | revealed the GHM<br>that one direct car<br>contents of their jo                                 | May 28, 2008 at 2:39 IRP failed to provide ended to staff and two nurses ob descriptions discussining of their employments.  | evidence<br>s had the<br>sed with                               | 1203                                |  |                                       |                          |
| I 206                                   | annually thereafte certification that a performed and the would allow him o duties.             | rior to employment ar<br>r, shall provide a phys<br>health inventory has<br>at the employee's he<br>r her to perform the re  | sician ' s<br>been<br>alth status<br>equired                    | l 206                               | I 206 In the future the QMR the HR Department w  | rill                                  | 6/16/08                  |
|   | Based on interview GHMRP failed to prior to employme provided evidence that documented and that | of met as evidenced by and record review, ensure that each empent and annually there e of a physician's certian health inventory had at the employee's heaver her to perform the record. | the<br>bloyee,<br>after,<br>ification<br>if been<br>alth status | ·                                   | ensure all employee r<br>are updated accordin<br>policy.  See attached health<br>certificates. |                                       |                          |
|   | Professional (QM personnel files on revealed the GHM  | Qualified Mental Reta<br>RP) and review of the<br>May 28, 2008 at 2:39<br>IRP failed to provide on<br>a certificates were on   | e GHMRP's<br>PM<br>evidence                                     |                                     |  |                                       |                          |

|                          |  |   |  |                     |  | FORM                           | APPROVED                 |  |  |  |
|--------------------------|--|---|--|---------------------|--|--------------------------------|--------------------------|--|--|--|
|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIE   |  | A. BUILDIN          | PLE CONSTRUCTION   | (X3) DATE S<br>COMPLI          |                          |  |  |  |
|                          |  | 09G141  |  | B. WING             |  | - 05/30/2008                   |                          |  |  |  |
| NAME OF P                | ROVIDER OR SUPPLIER  |   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |                                |                          |  |  |  |
| METRO I                  | HOMES  |   | 1433 NORTHGATE ROAD, NW<br>WASHINGTON, DC 20012  |                     |  |                                |                          |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)               |   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |  |  |  |
| I 228                    | Continued From pa  | age 3   |  | I 228               |  | ~~~                            |                          |  |  |  |
| l 228                    | 3510.5(e) STAFF 1  | FRAINING  |  | 1 228               |  |                                |                          |  |  |  |
|                          | limited to, the follow<br>(e) Resident's righ  | nts;  |  |                     |  |                                |                          |  |  |  |
|                          | Based on observat<br>review, the GHMRI<br>effectively trained i  | met as evidenced by<br>tion, interview, and re<br>P failed to ensure sta<br>n maintaining resider<br>the three residents (<br>the facility.   | cord<br>Iff were<br>nts'                         |                     | I 228  |                                |                          |  |  |  |
|                          | The finding include  | es:   |  |                     | Refer to W 189   |                                |                          |  |  |  |
|                          |  | o provide evidence th<br>lined on assisting Re<br>opriately.  |  |                     | Welet to M 189   |                                |                          |  |  |  |
|                          | on May 28, 2008 a resident was weari pants appeared to material and fit closher Adult Protective seen. When staff Resident #1's pant | sident #1 entering the t 3:37 PM revealed the gyellow crop pants be made of a cottonsely to the resident a e Undergarment (AP) were queried as to the sand observation of assisted the Resident | ne The Ilike Illowing U) to be e fit of her APU, |                     |  |                                |                          |  |  |  |
|                          | again observed to  | at 12:20 PM, Residen<br>be wearing pants tha<br>ession of the resident  | t fit  |                     |  |                                |                          |  |  |  |

was observed in the front of the resident's pants and in the back. Interview with the staff revealed that the resident had recently gained weight and many of her pants fit too closely. After the discussion with the staff member, Resident #1 was escorted to her room and was assisted with

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPL IDENTIFICATION N  09G141   |   |   | (X2) MULTI<br>A. BUILDING<br>B. WING | PLE CONSTRUCTION  G  | (X3) DATE SURVEY COMPLETED  05/30/2008 |   |  |
|--------------------------|--|---|---|--------------------------------------|--|--|---|--|
| NAME OF F                | ROVIDER OR SUPPLIER  | •   | STREET ADI  | DRESS, CITY, S                       | STATE, ZIP CODE  |  |   |  |
| METRO                    | HOMES  |   |   | RTHGATE ROAD, NW<br>GTON, DC 20012   |  |  |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>LSC IDENTIFYING INFORM/  | FULL  | ID<br>PREFIX<br>TAG                  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CO CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  |   |  |
| 1228                     | ensure staff were of Resident #1 with do to maintain levels  | es. survey, the facility faile effectively trained to a fressing appropriately of privacy. siency Report Citation   | issist<br>in order  | 1 228                                |  |  | , |  |
| 1,014                    | After medical services GHMRP shall proringuardian, his or he no guardian, or the sponsoring agency soon as possible, it documentation no after the incident.  This Statute is not Based on interview GHMRP failed to eservices were secunusual incidents in guardian, followed documentation of than forty-eight (48 one of the three rein the sample.  The findings including the facility's incider corresponding investigation of the facility's incider corresponding investigation. | ices have been secur<br>inptly notify the reside<br>or next of kin if the reside<br>or next of kin if the resident of the<br>of the resident of the<br>of the resident of the<br>followed by written no<br>later than forty-eight of<br>the met as evidenced by<br>or and record review, the<br>ensure that after meditured, prompt notification<br>was made to the resident of | nt 's ident has ident has ident has ident has ident has ident as itice and (48) hours included included intal included | 1017                                 | I 374<br>Refer to W 148  |  |   |  |

Health Regulation Administration STATE FORM

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  |  | (X2) MULT               | IPLE CONSTRUCTION                          |   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|--|-------------------------|--|---|-------------------------------|--|
|                          |   | is a second residence of the s | MDER.  | A. BUILDIN<br>B. WING _ |  | <del></del>   |                               |  |
|                          |   | 09G141   | 1  |                         |  | 05/3  | 30/2008                       |  |
| NAME OF P                | PROVIDER OR SUPPLIER  |  |  |                         | STATE, ZIP CODE                            |   |                               |  |
| METRO                    | HOMES   |  |  | THGATE R                |  |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORM  | FULL   | ID<br>PREFIX<br>TAG     | (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                               |  |
| 1 374                    | Continued From page 5   |  |  | l 37 <b>4</b>           |  |   |                               |  |
|                          | reported noticing R The resident was o other residents on a upon visual examin leg, near her left thi examination of the human bite mark w Interview with the fa 2008 revealed Resi Continued review o however, failed to p | acility's QMRP on Ma<br>ident #1 had a legal of<br>f the facility's incider<br>provide evidence that<br>ardian had been notif  | ally hard." Id next two ented that left pant oser that a  ay 28, guardian. It report |                         |  |   |                               |  |
| 1 379                    | <br>  3519.10 EMERGEN   | NCIES  |  | I 379                   |  |   |                               |  |
|                          | each GHMRP shall Health, Health Faci unusual incident or interferes with a resarrangement, well to places the resident be made by telephotollowed up by writter.  | porting requirement notify the Departme lities Division of any event which substarsident 's health, welf being or in any other at risk. Such notification immediately and en notification within urs or the next work  | nt of other otially are, living way ution shall shall be                             |                         | I 379<br>1.&2. Refer to W 1                | .48   |                               |  |
|                          | Based on interview GHMRP failed to er Health, Health Faci required (both immedy written notification incidents that substresident's health, for   | met as evidenced by and record review, the Departmer lities Division was not ediately notified and on within 24 hours), cantially interfered with two of the three reset 2) included in the safety.  | he int of int of intified as followed of unusual ith a sidents                       |                         |  |   |                               |  |

Health Regulation Administration

|                          |   | (X1) PROVIDER/SUPPLIE   |   | (X2) MULTIPI              | LE CONSTRUCTION  | (X3) DATE S<br>COMPLI             | E SURVEY<br>PLETED       |  |
|--------------------------|---|---|---|---------------------------|--|-----------------------------------|--------------------------|--|
|                          |   | 09G141  |   | B. WING                   |  | 05/3                              | 0/2008                   |  |
| NAME OF F                | PROVIDER OR SUPPLIER  | 333111  | STREET ADD  | DRESS, CITY, ST           | ATE, ZIP CODE  |                                   |                          |  |
| METRÓ                    |   |   |   | THGATE RO.<br>TON, DC 200 |  |                                   |                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA   | FULL  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |  |
| I 379                    | 79 Continued From page 6  |   |   | 1 379                     |  |                                   |                          |  |
|                          | May 29, 2008 at 1: May 23, 2008 she house manager ind why the client was Ted Hose was too manager she proce Hose off and indic crying. Further interevealed the facility facility at that time, afforementioned co with the house ma the medication nur According to the ho nurse indicated that toe and contact the The house manages staff was aware the bothering her and monitored her toe.  Continued interview May 30, 2008 at 12 observed a fungus May 23, 2008. Co house manager re | ne facility 's house may 25 PM revealed that observed Client #2 coldicated that she did norying, but thought motight. According to the eded to take the cliested that the client sterview with the house y's medication nurse and was informed of concern. Continued in mager revealed that se to examine the client set on the edit she would check the facility's nurse coorder said she made sure at Client #2's toe had to make sure that the would interview with the house mare 2:46 PM, revealed that is on Client #2's foot on thinued interview with vealed a direct care set. | on Friday, rying. The ot know haybe her he house ent's Ted opped manager was in the f the terview he asked ent. edication e client's dinator. e that the been y hager on at she n Friday, n the staff |                           |  |                                   |                          |  |
|                          | report that someth toe. The house m instructed the staff observation and to when she comes to Review of the faci 28, 2008 at 10:26  | Saturday, May 24, 200 ing was wrong with Canager indicated that ito be sure to docum inform the medication administer medicated lity's incident reports AM failed to evidence ident had been reports.   | client #2's she ent her on nurse ions.  on May e the  |                           |  |                                   |                          |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION  A. BUILDING | (X3) DATE SURVEY<br>COMPLETED |
|---|------------------------|---|-------------------------------|
|   | 09G141                 | B. WING                                 | 05/30/2008                    |

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1433 NORTHGATE ROAD, NW

| METRO HOMES              |  | WASHINGTON, DC 20012                                    |                     |  |                          |  |
|--------------------------|--|---|---------------------|--|--------------------------|--|
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |  |
| I 379                    | Department of Health immediately and followed by written notification within 24 hours as required.  2. Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports, including available corresponding investigative reports, on May 28, 2008, beginning at 10:30 AM revealed the following:  On November 20, 2007, day program staff reported noticing Resident #1 crying "really hard." The resident was observed to be seated next two other residents on a sofa. Staff documented that upon visual examination, Resident #1's left pant leg, near her left thigh was wet. After closer examination of the area, staff revealed that a human bite mark was observed. Continued review of the facility's incidents failed to provide evidence that the incident was reported immediately to the Department of Health as |   | 1379                | DEFICIENCY)  |                          |  |
| I 422                    | required.  3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, and assistance to residents in accordanthe resident 's Individual Habilitation Plates and the resident is not met as evidenced by Based on interview and record review, the GHMRP failed to ensure habilitation, transsistance was provided to its residents accordance with their Individual Habilitat Plan(s), for one of the three residents (Fig. 1) included in the sample.  The finding includes:  Review of Resident #1's records on Materials.  | training ace with an.  /: he ining and in tion Resident | 1 422               | I 422<br>Refer to W159-2   |                          |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  |                     | ` ´COMPL  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|---|---|---------------------|---|-------------------------------|--------------------------|
|   |  | 09G141  |   |                     | B. WING 05/3  |                               |                          |
| NAME OF P   | ROVIDER OR SUPPLIER  |   | STREET AD   | DRESS, CITY,        | STATE, ZIP CODE   |                               |                          |
|   |  | RTHGATE ROAD, NW<br>GTON, DC 20012  |   |                     |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | FULL  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                               | (X5)<br>COMPLETE<br>DATE |
| 1 422   | Continued From page 8  |   |   | I 422               |   |                               |                          |
|   | at 10:50 AM reveal Individual Support I 18, 2007. Interview Retardation Profes 2008 and further rerevealed that at the interdisciplinary tea objectives including Given verbal promptoilet appropriately consecutive month Further interview withe resident's record that the aforemential been implemented. | ed the resident had a Plan (ISP) dated Dec with the Qualified No sional (QMRP) on Meview of Resident #1' etime of the ISP means recommended program for the following:  pts, Resident #1 will 80% of the trials for second program objectioned program objections.  | tember Mental ay 29, s record eting, the ogram use the three eview of evidence tive had |                     |   |                               |                          |
| 1 424   |  | ATION AND TRAINI  |   | l 424               |   |                               |                          |
|   |  | n at least every six (6   |   |                     |   |                               |                          |
|   | (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan;  |   |   |                     | I 424<br>Refer to W 255   |                               |                          |
|   | Based on interview GHMRP failed to e made at least ever resident successfu one of the three re in the sample.  | met as evidenced by and record review, the same program revisity six months or when ally completed the object of the contract | the<br>ions were<br>n a<br>jective, for   |                     |   |                               |                          |
| Loolth Door   | The finding include lation Administration  | · ·   |   |                     |   |                               | 1                        |
| STATE FOR   |  |   |   | 6899                | 3E6Q11  | If continua                   | ation sheet 9 of 10      |

| AND PLAN OF CORRECTION IDENT |  | (1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |   | (X3) DATE SURVEY COMPLETED - 05/30/2008 |        |  |
|------------------------------|--|--|--|--|---|---|--------|--|
|                              |  | 09G141   | CTREET AD  | DBESS CITY S                                     | TATE ZIR CODE   | 05/3                                    | 0/2008 |  |
| 1433 NOR                     |  |  | DRESS, CITY, STATE, ZIP CODE  RTHGATE ROAD, NW  GTON, DC 20012 |  |   |   |        |  |
| (X4) ID<br>PREFIX<br>TAG     | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | (X5)<br>COMPLETE<br>DATE                |        |  |
| 1 424                        | Review of Residen at 10:50 AM, revea Support Plan (ISP) December 18, 200 and review of the review of the review objectives current ISP year:  - Given verbal cues and down stairs, 5 for 12 consecutive  - Given physical as ambulate for 10 coweek for 12 consecutive week for 12 consecutive review on May 30, achieved the criter program objectives 2007. According to review, the objective Resident #1 in 2000 the QMRP failed to program objectives Resident achieved | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 9  Review of Resident #1's record on May 29, 2008 at 10:50 AM, revealed the resident's Individual Support Plan (ISP) meeting was held on December 18, 2007. Interview with the QMRP and review of the resident's corresponding IPP at 4:12 PM revealed the team recommended program objectives including the following for the |  | 1424   | DEFICIENC   | <del>(1)</del>                          |        |  |
|                              |  |  |  |  |   | ,                                       |        |  |